

Bureau Talk

February 2015

Bureau of Home Care and Rehabilitative Standards

Missouri Department of Health and Senior Services

<http://health.mo.gov/safety/homecare/>



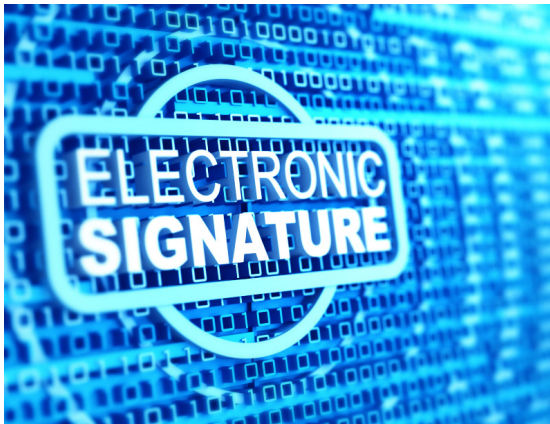
New Publishing Schedule

In May, *Bureau Talk* outlined its new publishing schedule: February, May, August and November. However, the bureau's mandated activities keep increasing, and it has been unable to meet its quarterly deadline for publication. Therefore, *Bureau Talk* will now be published on an as-needed basis. The bureau will continue to notify agency administrators when the latest version is available so they can share it with their employees.

Bureau Welcomes New Employee

The bureau welcomes Dora Meller, R.N., its newest health facilities nursing consultant. Dora has a wealth of experience, including surveying ambulatory surgical centers and hospitals. She also has been a quality manager, infection control nurse, QAPI coordinator, HIPAA privacy officer, performance improvement/risk-management coordinator, and compliance officer. Dora will survey both home health and hospice agencies across the state. Please join us in welcoming Dora to the bureau team!

Electronic Signatures



Agencies and physicians continue to increase their use of electronic medical records. The question arises as to whether an electronic signature on a plan of care (485) is acceptable. Surveyors have no problem with an electronic signature on a 485; however, the bureau cannot make that determination for a fiscal intermediary (FI). Therefore, the bureau recommends that providers contact their FIs to determine if an electronic signature is acceptable for billing purposes.

Missed Visits

A patient may refuse a visit as ordered by a physician on the patient's plan of care. In those instances, an agency must document that it attempted to reschedule the visit in the patient's medical record. If the rescheduling is not successful, an agency must notify the physician of the missed visit.

Corporate Sharing of Staff

Each provider, even if under the Umbrella of a large corporation, has its own Medicare provider number and is considered its own agency. Therefore, if an employee transfers to another agency within a corporation, that agency has to run new background checks on and provide Alzheimer's training, aide competency, and other required training to that employee.



Prescriptions Found in the Home

When a clinician finds a new prescription bottle in a patient's home during a home visit, the prescription label on the bottle serves as a physician's order. However, the clinician needs to document the new prescription in the patient's clinical record and update the medication record. If the prescription is not by the patient's attending physician (the physician who monitors the patient's home health plan of care), then the clinician needs to call the attending physician and document whether he or she concurs with the new order.



Social Workers

The bureau has received several phone calls lately regarding how the qualifications of a Licensed Clinical Social Worker fit in with home health and hospice regulations. We consulted the executive director of the State Committee for Social Workers for clarification. Following is the information we obtained.

In Missouri, one must have a degree in social work from a CSWE-accredited school to call oneself a social worker. The LBSW requires a bachelor's degree, and the LMSW and LCSW require a master's degree. Each level requires passage of a competency exam (baccalaureate, masters, clinical).

In order to get an LCSW license, one must first get licensed as an LMSW, work for a minimum of two years under registered supervision, and then pass the clinical exam. The supervision has to be approved and registered with the State Committee for Social Workers.

A clinical social worker, or a master social worker under the supervision of a clinical social worker, is the only social worker that may do the following:

- Administration and interpretation of assessment checklists.
- Child or adult custody assessments and recommendations.
- Crisis intervention with psychotherapy.
- Diagnosis of disorders with a diagnostic code.
- Intervention methods using specialized and formal interactions.
- Provide counseling services with psychotherapy.
- Treatment planning and evaluation.

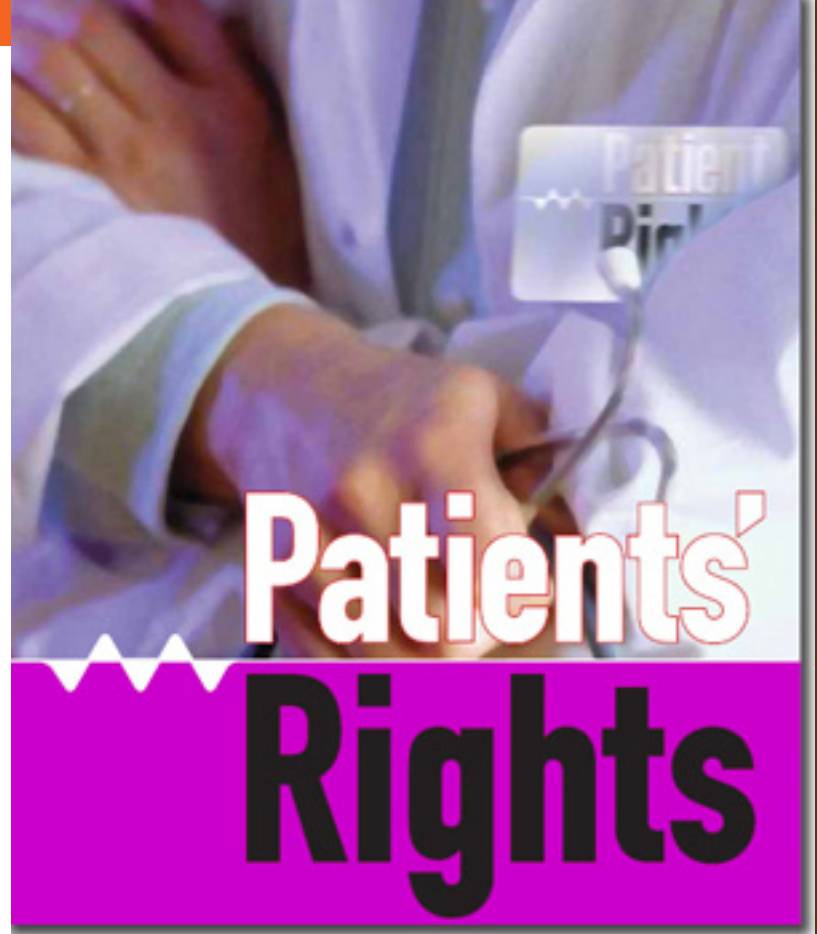
In summary, if surveyors see that a social worker has an LCSW, that's all they need. If a social worker does not have an LCSW, then surveyors will need to see the social worker's MSW diploma.

Home Health

Proposed Conditions of Participation

The proposed Home Health CoPs were posted Oct, 9, 2014. The proposed rule is in the Federal Register at <http://tinyurl.com/lwgz4n8>. A few of the proposed changes include:

- A description of the role of the administrator and provisions for when the administrator is not available.
- Changes in the definition of a “branch” and a new standard addressing the parent-branch relationship.
- Removal of the requirement for the 60-day summary to the physician.
- Removal of the requirement to have a professional advisory group.
- Changes to patient’s rights.
 - Right to participate in, be informed about, and consent or refuse care.
 - Right to participate in, and be informed about, the comprehensive assessment, goals and care preferences.
 - Right to access auxiliary aids and language services.
 - Right to be informed about the agency’s policies governing admission, transfer and discharge.
- A listing of criteria by which agencies can discharge or transfer patients.
- Requiring agencies to investigate complaints by patients, investigate allegations of mistreatment, neglect, or verbal, mental, psychosocial, sexual and physical abuse, and misappropriation of patient property.
- Requiring the comprehensive assessment to include the need for physical, psychosocial, emotional and spiritual care.
- Requiring each plan of care to contain measurable outcomes.
- Having an agency’s governing body establish a QAPI requirement.
- Establishing an infection prevention and control CoP.
- Addressing qualifications for home health aides.



Home Health

State Operations Manual

The Certification Process, Chapter 2 of the State Operations Manual (SOM), has again been revised, effective Oct. 31, 2014. **(ATTACHMENT B)**

Some of the revisions for home health pertain to the following areas:

- Branch Approvals.
- Separate Entities.
- HHA Change of Addresses.
- Agency Move after Certification Survey and Before Final Medicare Approval.
- Guidelines for Determining Standard Survey Frequency.
- Surveyor Worksheets.
- Accessing OBQM, OBQI, and Process Based Quality Improvement (PBQI) Reports.
- OASIS and the Medicare Home Health Prospective Payment System.
- Wound Ostomy Continence Nurses Society (WOCN) and the National Pressure Ulcer Advisory Panel (NPUAP) OASIS Guidance.

Complaint Procedures, Chapter 5 of the SOM, also have seen some revisions. The effective revision date is Sept. 19, 2014. **(ATTACHMENT C)**

Most of the revisions resulted in clarification of the following areas:

- Priority Assignment, Priority Definitions, Clarification of Immediate Jeopardy, Non-Immediate Jeopardy – High Priority, Non-Immediate Jeopardy – Medium Priority and Non-Immediate Jeopardy – Low Priority.
- Administrative Reviews/Offsite Investigations.
- Referrals.
- No Action is Necessary.

These revisions clarified the actual investigative process — presurvey, entrance and exit conferences, reporting procedures, investigative procedures, etc.

Chapter 5, Complaint Procedures, addresses both deemed and non-deemed providers.



Homebound Status



CMS Transmittal 192 (Change Request 8818), published Aug. 1, 2014, clarifies the definition of a patient being “confined to the home” to accurately reflect that definition as articulated in Section 1835(a) of the Social Security Act. In addition, vague terms such as “generally speaking” have been removed. The clarification will prevent confusion, promote clearer enforcement of the statute, and provide more definitive guidance to HHAs in order to foster compliance. The implementation date for this change is Sept. 2, 2014. Please find attached Chapter 15, Section 60.4.1, from the Medicare Benefit Policy Manual. **(ATTACHMENT A)**

Home Health



Telemonitoring

Does home telemonitoring require an order? Yes. The Centers for Medicare & Medicaid (CMS) verified that an agency needs an order for telemonitoring. Telemonitoring needs to be incorporated into the care plan. The order should be specific and individualized and should include parameters to report to a physician. Home telemonitoring cannot take the place of a visit. If the order is for three visits a week, the agency can't make two visits and count telemonitoring as the third.

Orders for "Teaching" on the POC

Physicians' orders may stipulate that a clinician educate his or her patient on a disease and its history. If so, surveyors expect a clinician to document the teaching and the patient's comprehension in the patient's medical record. Clinicians are not expected to educate a patient on every visit. However, if a patient continues to lack understanding of the disease, then clinicians should use good judgment about when to review and reinforce the information. Each patient's comprehension and understanding will vary. Some patients may only need review; others may require it on an ongoing basis.

WHERE HAVE ALL THE *Nurses Gone?*

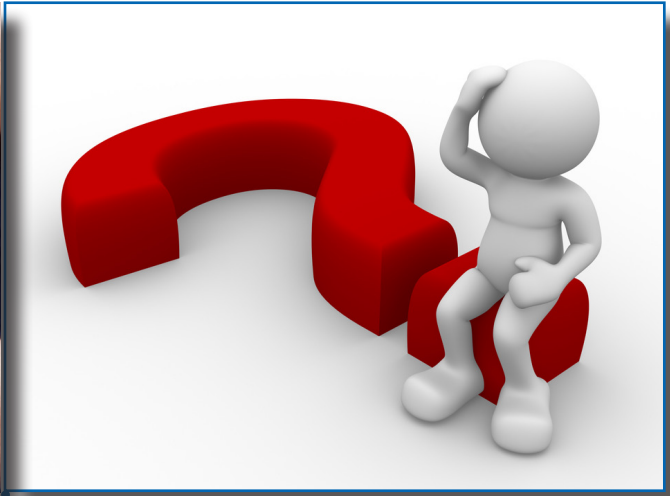
THE IMPACT OF
THE NURSING SHORTAGE
ON AMERICAN HEALTHCARE

Hospice

On Oct. 3, 2014, CMS published "S&C: 15-01-Hospice." That document informs state survey agencies that hospices have a longer period of time to qualify for an "extraordinary circumstance" exemption when they believe a nursing shortage has affected their ability to hire sufficient numbers of nurses. The effective date of this policy continues through Sept. 30, 2016.

Please refer to the attached S&C to see what an agency needs to do in order to qualify for an "extraordinary circumstance" exemption. **(ATTACHMENT D)**

Hospice



Impact Act

On Oct. 6, 2014, President Obama signed into law the “Improving Medicare Post-Acute Care Transformation Act of 2014” (IMPACT Act). The IMPACT Act includes provisions creating greater oversight and increased transparency within the hospice community.

The law greatly affects the bureau because it mandates surveys of Medicare-certified hospice providers at least every three years for the next ten years, at a minimum. The law’s implementation date is April 6, 2015. The Department of Health and Senior Services is currently working with the bureau to determine how it will be able to meet this new federally mandated requirement.

Miscellaneous Hospice Questions

The bureau recently received several hospice regulatory questions via email from providers. All providers can benefit from the responses provided below.

Q: Does the discharge summary for a revocation, discharge other than death, or a transfer have to be sent to the physician?

A: Yes.

Q: Can a home health aide’s orientation be counted toward their 12-hour regulatory annual training requirement? Can a hospice volunteer’s orientation count as volunteer hours?

A: Yes, the aide’s orientation CAN count towards the 12-hour regulatory annual training requirement. Time spent in orientation for a volunteer CANNOT count towards an agency’s volunteer hours.



OASIS C1/ICD-9 Version

By now all home health agencies have begun using the new OASIS C1/ICD- 9 Version of the OASIS data set. In October and November, the Missouri Alliance for Home Care sponsored five regional OASIS trainings throughout the state. Joyce Rackers, Missouri's OASIS education coordinator, provided training on the OASIS C1/ICD- 9 Version. The turnout was good, but the bureau would like to see many more clinicians benefit from the training. Therefore, in December, the bureau sent Rackers' PowerPoint training presentation to all home health administrators via Listserv to share with their employees. The PowerPoint covers both OASIS C and the OASIS C1/ICD- 9 Version. Rackers hopes to update the PowerPoint to cover only OASIS C1/ICD -9 over the next couple of months. Agencies will be notified via Listserv when it is available on the bureau's website.

New OASIS C1/ICD-9 Guidance Manual

On Dec. 2, 2014, CMS posted a FINAL VERSION of the OASIS-C1/ICD-9 Guidance Manual. The newly posted version contains only a couple of changes to the previous DRAFT version:

- The version date has changed from June 2014 to January 2015 on the cover sheet and on the footers throughout the manual.
- The "All Items" and "Time Point Versions" of the data set, contained in Chapter 2 of the manual, have been updated with the new OMB-approval number, and the word "DRAFT" has been removed from the data set footers.

Other than those updates, no other content in the Guidance Manual has changed since the June 2014 draft files were posted.

Please visit <http://go.cms.gov/1mJLIhc> for more information.

Q & As

As always, it is imperative that clinicians keep updated on the latest Q&As published by CMS. The master copy of the OASIS C1/ICD-9 Q&As (last updated June 2014) can be accessed at www.qtso.com. Click on *OASIS* and then on *Users Guide & Training*.

Two sets of Quarterly Q&As have been published since the last *Bureau Talk*—the first in October 2014, the second in January 2015. They can be accessed at <http://www.oasisanswers.com>. Click on *OASIS Links & Resources*. Please share the Q&As with your clinical staff for significant guidance related to such things as:

- Handling episodes where ordered nursing services are refused by a patient or found not to be medically necessary.
- Managing “date of referral” when the referral source will not be giving orders or overseeing the patient’s home health plan of care.
- New guidance related to skin breakdown within a healing muscle flap.
- Determining healing status when hypergranulation is present.
- Answering M2102 when a patient refuses assistance from a willing/able caregiver.
- Using clinical judgment in selecting OASIS responses.
- Completing a resumption of care visit prior to receiving physician orders.
- Qualifications of staff conducting OASIS audits.



- Selecting appropriate responses when a patient can’t remember immunization history.

Agencies should pay particularly close attention to Question #2 regarding M0104 in the October 2014 Q&As. The guidance differs somewhat from previous Centers for Medicare & Medicaid Services (CMS) guidance, as outlined in the August 2013 Bureau Talk.

The most current published CMS guidance must be followed. Therefore, agencies should follow the October 2014 quarterly Q&As.

For instance, if an agency receives a referral from a hospitalist who is not going to monitor a patient’s plan of care, then the agency must ensure another physician will do so. The referral date is the day the agency contacts that physician and obtains his or her agreement with the hospitalist’s referral and further orders.



Home Health Compare (HHC)

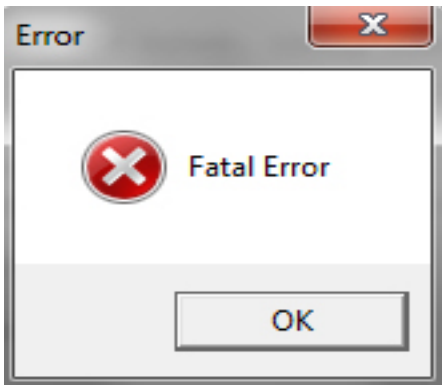
In October 2014, the Strategic Healthcare Program (SHP), a data analysis program for home health agencies, received CMS guidance on several questions they posed. Below are those questions.

Q: The final rule stated that the new 30-day rehospitalization measure will be reported in January. Will the current 60-day hospitalization measure remain or will it be removed from Home Health Compare?

A: The new 30-day rehospitalization measure will not be reported on HHC in January 2015. It may be reported in mid-July 2015. The current 60-day hospitalization measure will remain on Home Health Compare.

Q: There are two new measures that have been discussed: "Depression Screening Conducted with Follow-up Plan" and "New or Worsened Pressure Ulcer." Do you know when or if these measures will be reported?

A: The "Depression Screening Conducted with Follow-up Plan" and "New or Worsened Pressure Ulcer" measures are available only after OASIS-C1/ICD-9 is in effect (Jan. 1, 2015). Therefore, these two measures will be available for reporting only after sufficient data are collected. The "Depression Screening Conducted with Follow-up Plan" metric is a process measure and does not require risk adjustment. This measure could be posted as early as mid-July 2015. However, the "New or Worsened Pressure Ulcer" metric is an outcome measure and will need to be risk adjusted. The earliest this measure could be reported is January 2016 to allow sufficient data to be collected to support risk model development.



The OASIS ASAP system was enhanced on Jan. 12, 2015, at 5:30 p.m. (ET) to correct some recently identified issues. Below is a list of the enhancements:

Corrected Editing of Item M0016 Branch ID Number

- The ASAP system was incorrectly processing data submitted in item M0016 Branch ID Number and that caused some OASIS records to be wrongfully rejected.
- To correct the issue, three OASIS errors associated with the M0016 Branch ID field were enhanced and a new edit was added. The affected errors, including the error message number and description and a brief explanation of the enhancements, are listed below.

-4690 Invalid Branch

- If the assessment were performed by an HHA with no branches or by a subunit with no branches, then M0016 must contain N (No Branches). This is a fatal error.
 - The ASAP system was enhanced to evaluate for open branches per the certification in effect at the time of the assessment, based on the assessment's Effective Date.
 - If no open branches are found, ASAP will enforce the requirement for submission of an 'N' in M0016.

-4700 Invalid Branch

- If the assessment were performed by the home office of an HHA with branches or by the home office of a subunit with branches, then M0016 must contain P. This is a fatal error.
 - HHAs with closed branches were incorrectly receiving this error. HHAs were correctly submitting an 'N' (No Branches) in item M0016, but the record was being rejected. The rejection was occurring because the ASAP system was not evaluating whether the branches were open per the certification in effect at the time of the assessment, based on the Effective Date of the assessment. When ASAP identified closed branches for the HHA, the system expected submission of a 'P' in M0016. This was inaccurate. The system should only have been considering open branches when expecting a 'P' (Parent) value in the item.
 - The ASAP system was enhanced to evaluate for open branches per the certification in effect at the time of the assessment, based on the Effective Date of the assessment. ASAP no longer considers closed branches for this edit and will not reject records containing an 'N' submitted from an HHA with closed branches.
 - Providers whose records were inappropriately rejected by the ASAP system prior to the system enhancement will be required to resubmit the assessments. The QTSO Help Desk will contact the affected providers and notify them of such.

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-4720 Invalid Branch

- The standard branch ID submitted in M0016 is not currently a branch ID associated with this agency. This is a warning message.
 - The ASAP system was correctly checking the submitted M0016 Branch ID value to the database to determine whether the branch had been closed; however, the system did not compare the assessment's Effective Date to the termination date for the branch.
 - The system should have compared the Effective Date of the assessment to the branch's termination date to:
 - o Determine if the branch were closed per the certification in effect at the time of the Effective Date of the assessment and return error -4720.
 - o Determine if there were no termination date for the branch per the certification in effect at the time of the Effective Date of the assessment, which would indicate that the branch was open and not issue error -4720.
 - o This edit was enhanced to compare the Effective Date of the assessment to the termination date for the branch and appropriately return the error.

-929 Multiple Branch ID Records Found

- This is a new ASAP system error that will be issued if the submitted Branch ID in M0016 matches multiple Branch ID records in the database. This is a fatal error.
- This error occurs when there is a data integrity problem with the provider branch data in the provider branch information table.
- Providers will be instructed to contact the OASIS Automation Coordinator if this error returns on the Final Validation Report. The OASIS Automation Coordinator must contact the appropriate state agency personnel to correct the data issue in the ASPEN software that is causing the data integrity problem. Once the data issue is resolved, the HHA must resubmit the record.
- The new error message has been added to Section 5 – Error Messages of the OASIS Submission User's Guide.

Error -4820 (Invalid HIPPS Values) Enhancements

- Error -4820 was incorrectly returning for some OASIS records.
 - This was occurring for OASIS records where the *M2200 Therapy Need Not Applicable* (M2200_THER_NEED_NA) item contained a 1 (one), indicating the item was checked. The OASIS item set contains instructions indicating that no case mix group will be defined by this assessment if *M2200 Therapy Need Not Applicable* is checked.

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Oasis

USER MANUAL

- The ASAP system was inappropriately calculating the HIPPS Code when the submitted *M2200 Therapy Need Not Applicable* was checked (contained a 1). Since the ASAP recalculated the HIPPS code, it applied the edits comparing the submitted to the recalculated HIPPS values and issued this edit. The grouper edits will not be applied when the grouper is not called.

- The ASAP system was enhanced to call the grouper for all records and issue the grouper messages except during the instances identified below:

- If the record is rejected because of a FATAL error

OR

- If item *M2200 Therapy Need Not Applicable* (M2200_THER_NEED_NA) is equal to 1 (checked).

Error -4820 (Invalid HIPPS Values)

- Error -4820 was enhanced to display the submitted HIPPS Version Code (SUBM_HIPPS_VERSION) value on the Final Validation Report.
- The Submitted HIPPS Version Code was accurately being stored with the accepted record in the database, but the value was not displaying when this error returned on the Final Validation Report.

Error -904 – Invalid XML File Format

- Early in the record processing phase, the ASAP system evaluates the submitted record to validate whether it is a valid XML file. This error has several causes:
 - The submitted file is not an XML file.
 - The XML file is not well-formed or is not coded in the required ASCII character encoding.

- The XML file contained item response values, not including the delimiters, which were greater than 100 characters in length.
- The XML file contained tags, not including the delimiters, which were greater than 30 characters in length.
- A number of record rejections due to the invalid XML file format have been reported to the QTSO Help Desk. To assist end users and vendors to understand why the records may be rejected with error -904, Section 5 – Error Messages, the OASIS Submission User's Guide was updated to contain the following tips:
 - Beginning and ending tags must enclose the entire assessment record.
 - Beginning and ending tags must enclose each item of the assessment record.
 - Tags names must not exceed 30 characters. This does not count the delimiters (< >) in which the tags must be enclosed.
 - Values submitted between the beginning and ending tags for an item must not exceed 100 characters.

Note: When error -904 occurs, the file cannot be processed by the ASAP system; therefore, an ASAP system-generated final validation report cannot be created. If a user does not have a system-generated final validation report in the Validation Report (VR) folder in the CASPER Reporting application, the submitter of the file should request the OASIS Submitter Final Validation report.

OASIS Submission User's Guide

Section 5 – Error Messages of the OASIS Submission User's Guide—was updated as identified above and is available in the following locations:

- CMS QIES Systems for Providers – OASIS Welcome Page.
- OASIS User Guides and Training page on the QTSO website.
- State Download page on the QTSO site.



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Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services' Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO, 65102-0570, 573-751-6336. Hearing- and speech-impaired citizens can dial 711.

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